STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155495	A. BUILDING 00 B. WING	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PADDOCK SPRINGS	2695 SHELDON STREET WARSAW, IN 46582

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 8, 9, 10, 11, 15 & 16, 2024 Facility number: 000491 Provider number: 155495 AIM number: 100291230 Census Bed Type: SNF/NF: 45 SNF: 12 Residential: 33 Total: 90 Census Payor Type: Medicare: 12 Medicaid: 36 Other: 42 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 10/22/2024	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify the physician of medications held for 1 of 1 resident reviewed for physician notification (Resident 4). Finding includes:	F 0580	F580 – Notification of Changes 1 No adverse effects were noted to Resident 4. 2 The deficient practice has the potential to affect all residents in the facility. 100 % audit of all	11/07/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The clinical record for Resident 4 was reviewed on 10/9/2024 at 1:27 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, chronic kidney disease, heart failure, schizoaffective disorder, psychotic disorder with known delusions, hypertension, bipolar disorder, depression, anxiety, diabetes mellitus, dementia and borderline personality disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 7/18/2024, indicated the resident was taking an antidepressant medication, an antianxiety medication and a diuretic medication. The current Physician's Orders for Resident 4, initiated on 8/22/2023, included Bumetanide medication (diuretic) 1 mg (milligram) 1 tablet orally, twice a day for chronic systolic and diastolic congestive heart failure. A current Care Plan, revised on 7/17/2024, indicated Resident 4 received diuretic medication. Interventions included, but were not limited to: medications per physician orders and report adverse drug reaction as needed. The June 2024 Medication Administration Record (MAR) indicated Resident 4 had the evening Bumetanide dose held due to low blood pressure on the following dates: 6/22/2024 and 6/24/2024. The August MAR indicated Resident 4 had the evening Bumetanide dose held due to low pressure on 8/4/2024. The September MAR indicated Resident 4 had Bumetanide dose held on 9/21/2024 in the evening for low blood pressure, on 9/22/2024 in the morning for low blood pressure and on 9/22/2024 in the evening for a low heart rate. There was no documentation the physician had		resident medication administration records have been reviewed for any medications that have been held in the last 4 weeks and provider reviewed documentation with no concerns. 3 Nursing staff educated on the process and policy for holding medications and provider notification. 4 The DHS or designee will review all resident administration records for held medications and appropriate notification weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. The DHS or designee will review any findings and corrective action monthly and in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as appropriate. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/07/2024	

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	been notified of the need to hold the Bumetanide medication due to Resident 4's low blood pressure or heart rate. During an interview, on 10/11/2024 at 10:59 A.M., QMA 1 indicated there was no policy or physician orders for parameters to hold diuretics for blood pressure or heart rate for Resident 4. QMA 1 indicated nursing staff should have notified the MD to obtain hold order for the Bumetanide medication. During an interview, on 10/11/2024 at 1:30 P.M., the Director of Nursing (DON) indicated staff should have notified the provider and documented the notification in the Electronic Medical Record (EMR). On 10/11/2024 at 1:34 P.M., the DON provided a policy titled, "Physician: Provider Notification Guidelines," dated 12/31/2023 and indicated the policy was the one currently used by the facility. The policy indicated, "ensure the resident's physician or practitioner is aware of ...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care ..." 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review, observation and interview, the facility failed to ensure interventions were in place to prevent a deep tissue injury (DTI) wound after admission for 1 of	F 0686	F686 – Treatment/Services to Prevent/Heal Pressure Ulcer 1 Resident 105 was affected	11/07/2024

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	2 residents reviewed for pressure ulcers. (Resident 105) Finding includes: The record for Resident 105 was reviewed on 10/10/2024 at 1:37 P.M. Diagnoses included, but were not limited to, right hip fracture, diabetes, chronic congestive heart failure and depression. A Hospital Transfer form, dated 10/4/2024, indicated Resident 105 had no skin issues to his heels at the time he was transferred to the facility. Resident 105 had been hospitalized for an acute right hip fracture with surgical repair. A facility Admission Observation form, dated 10/4/2024, indicated Resident 105's pedal (feet) pulses were present to both feet and the resident had weakness to both lower extremities. Under the section of the form, titled, Skin impairment, "Yes" was documented and the form indicated an "Occurrence" progress note was to be completed and include an assessment. There was no skin impairment assessment completed for Resident 105's right heel upon admission. A pressure ulcer risk assessment, dated 10/4/2024, indicated Resident 105 was a low to moderate risk to develop pressure injuries. A Baseline Care Plan, dated 10/4/2024, indicated a goal for the resident not to develop a pressure ulcer, or if a pressure ulcer was present, the wound would not worsen. Interventions included, but were not limited to, turn and reposition for care and use devices to optimize independent repositioning and transfers. There were no interventions to provide pressure relief to the resident's heels.		by the deficient practice. Treatments and interventions are in place including pressure relieving mattress, offloading heels, boot for pressure relief, and continued education to resident regarding not wearing shoe. Wound improving on discharge. 2 The deficient practice has the potential to affect all residents in the facility. 100 % audit of all resident skin has been completed. Braden assessments reviewed for all in-house residents. All residents have pressure-relieving mattresses, and weekly skin assessments continue for 100% of residents. No findings noted during skin sweep. 3 Nursing staff educated on the process and policy for skin assessments and updating provider of change in skin condition and orders and treatments updated appropriately. New admissions assessed for any skin impairments on admission, Braden assessment completed on admission and quarterly for any necessary updated interventions required. Weekly skin assessments continue for 100% of residents in facility. 4 The DHS or designee will review 5 residents skin integrity weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. The DHS or designee will review any findings and corrective action monthly and in the campus	

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	A Wound Management Detail Report, dated 10/4/2024, indicated Resident 105 had a DTI (deep tissue injury, damage to the soft tissue beneath the skin caused by pressure or shear forces) to the right heel that was present on admission. The wound measured 5 cm (centimeter) length x 5 cm width. There was no other description of the wound. Physician's Orders, dated 10/4/2024, included: Skin prep (fast drying protective dressing) to the right heel 3 times a day as a preventative measure. There was also an order for a preventative foam dressing to the right heel and it was to be changed every 3 days. The orders included instructions to provide pressure relief to the resident's right heel. A Care Plan, initiated on 10/6/2024, indicated Resident 105 was at risk for skin breakdown related to: (the area to indicate where the area was located was left blank). Interventions included, but were not limited to, avoid shearing skin during positioning, turning, and transferring, conduct weekly skin assessments, pay particular attention to resident's bony prominences, encourage and assist the resident to turn and reposition for comfort and as needed and to keep bed linens clean and dry. The plan did not specifically include interventions to prevent pressure on the resident's heels. A Care Plan, initiated on 10/10/2024, indicated the resident had a pressure ulcer, DTI, to the right heel. Interventions included, but were not limited to: Assess and record the condition of the skin surrounding the pressure ulcer, administer analgesics per physicians order, observe and report signs of infection (e.g., localized pain,		Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as appropriate. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/07/2024	

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	redness, swelling, tenderness, drainage, odor, and fever), observe for and report signs of pain related to the pressure ulcer, pressure reducing cushion to the wheelchair, treatment per physicians order, notify physician if treatment is not effective, weekly skin assessment, measurement and observation of the pressure ulcer and record, keep the resident as clean and dry as possible, minimize skin exposure to moisture and use a lifting device as needed for bed mobility (e.g. lift sheet, etc.) There were no specific interventions to ensure pressure relief to the resident's right heel. An NP Progress Note, dated 10/11/2024, indicated the resident had undergone a right hip replacement on 9/28/2024. The facility's wound nurse had called and discussed concerns regarding a possible DTI for Resident 105 on 10/6/2024. The wound NP indicated she had given the facility's wound nurse recommendations for the skin prep treatment and routine offloading procedures. The note indicated when she had assessed the resident on 10/11/2024, she noted a stage II pressure ulcer to the resident's right heel. She wrote treatment orders and recommended off-loading heel booties. During an observation, on 10/11/2024 at 9:32 A.M., Resident 105 was observed with shoes on both feet, seated in his wheelchair. The resident's shoes were positioned on the footrest pedals of the wheelchair. During an observation, on 10/11/2024 at 10:40 A.M. with the Wound Nurse Practitioner (NP) and the facility wound nurse, the following was observed on Resident 105's right heel: an opened wound approximately 5 cm (length) x 5 cm (width) with red granulation tissue and specs of a dark purple/black color in the middle and along the			

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	right side of the wound bed. The open wound had a white ring around the outside edge of the wound. The Wound NP indicated the area did not have any dead/necrotic tissue and staged it as a stage II pressure ulcer (an open sore or blister that indicated partial thickness loss of the skin). During an interview, on 10/11/2024 at 1:25 P.M., the Director of Nursing (DON) indicated the pressure area to the heel was not present on admission. The nurse had made a mistake when she documented it as present on admission as an ulcer. There was no other documentation in the chart that indicated the DTI was found on admission. The DON indicated the nurse realized she had coded the wound incorrectly on the Wound Management Detail Report, completed on 10/4/2024. The nurse had contacted the Wound NP and the wound should have been identified as "in-house acquired." When questioned as to why the current care plan for the foot ulcer did not include specific interventions to prevent pressure on the resident's heels, such as floating his heels, the DON indicated the resident's mattresses were "pressure relieving." During an observation, on 10/15/2024 at 12:02 P.M., Resident 105 was seated in the dining room with his feet covered with regular socks and his heels/feet resting on the floor. During an interview, on 10/15/2024 at 1:47 P.M., Resident 105 indicated he wore socks on his feet when he went to bed, but did not wear anything else on his feet. Resident 105 did not indicate staff ever placed a pillow underneath his lower legs to elevate his heels or staff placed booties on his feet. During an observation, on 10/16/2024 at 9:03			

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	A.M., Resident 105 was observed in his wheelchair. His right foot was resting on the floor with a foam dressing adhered to the middle of his foot and his heel exposed. There were no offloading booties in his room, even though the NP had recommended them on 10/11/2024. During an interview, on 10/16/2024 at 9:05 A.M., RN 5 indicated there were no booties located in the room and the resident should have had a bootie on his right foot. On 10/11/2024 at 2:45 P.M., the Director of Nursing provided the policy titled, "Guidelines for Pressure Prevention", dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... To maintain good skin integrity and avoid development of pressure ulcers. Care plan interventions shall be implemented based on risk factors identified in the nursing assessment. Interventions may include, but not be limited to: ...float heels as needed...Elevate heels off the bed-avoid use of heel protectors...." On 10/11/2024 at 2:45 P.M., the Director of Nursing provided the policy titled," Guidelines for General Wound and Skin Care", dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated"...5. Evaluate the need for a pressure reduction surface for bed/chair...or float heels/boots...." 3.1-40			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to administer a physician ordered	F 0755	F755 – Pharmacy Services/Procedures/Pharmacist/	11/07/2024

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	medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 12) Finding includes: The record for Resident 12 was reviewed on 10/11/2024 at 10:17 A.M. Diagnoses included, but were not limited to: heart failure, dementia, anxiety, depression and Bipolar disorder. The current Physician's orders for Resident 12 included an order for the resident to receive Lorazepam 0.5 mg daily for anxiety and agitation. The Medication Administration Record (MAR), dated August 2024, indicated the resident was to receive Lorazepam 0.5 mg daily for anxiety and agitation. The MAR indicated the resident did not receive the ordered Lorazepam from 8/4/2024 through 8/12/2024. On the section labeled " Reasons/Comments" was documented "Med Not Available," from 8/4/2024 to 8/12/2024, for the Lorazepam. During an interview, on 10/15/2024 at 10:26 A.M., the Director of Nursing indicated the physician should have been notified of the missed doses. During an interview, on 10/15/2024 at 1:38 P.M., the Director of Nursing indicated the nurse should have obtained the medication from the facility's Emergency Drug Kit (EDK) and called the Pharmacy. During an interview, on 10/15/24 at 1:49 P.M., LPN 11 indicated if a medication was not available in the medication cart, she would get in the EDK (emergency drug kit) to get the medications or call the pharmacy.		Records 1 No adverse effects were noted to Resident 12. 2 The deficient practice has the potential to affect all residents in the facility. 100 % audit of all resident's medications have been completed. Provider reviewed documentation related to unavailable medications with no concerns noted. Continue with collaboration with pharmacy with any concerns identified. 3 Nursing staff educated on the process and policy for unavailable medications and updating provider of any unavailable medications. 4 The DHS or designee will review 5 residents medication availability weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. The DHS or designee will review any findings and corrective action monthly and in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as appropriate. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/07/2024	

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	On 10/15/2024 at 4:05 P.M., the Director of Nursing provided the policy titled, "Unavailable Medications," undated, and indicated the policy was the one currently use by the facility. The policy indicated "...The facility must make every effort to ensure that medications are available to meet the needs of each resident...B. Facility personnel shall: 1). Notify the attending physician of the situation and explain circumstances, expected availability and optional therapy(ies) that are available... 2). Obtain a new order and cancel/discontinue the order for the non-available medication. 3). Notify the pharmacy of the replacement order...." 3.1-25(a)			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to clarify conflicting hospital discharge orders and previous medication orders for appropriate dosing of a blood pressure medication. This deficient practice resulted in a significant medication error which required hospitalization for 1 of 3 residents reviewed for hospitalization. (Resident 9) Finding includes: A record review was completed for Resident 9 on 10/10/2024 at 8:29 A.M. Diagnoses included, but were not limited to: congestive heart failure, hypertensive heart disease with heart failure, and essential hypertension Resident 9's record indicated she returned to the facility on 6/24/2024 at 1:30 P.M. after a hospitalization for sepsis, urinary tract infection	F 0760	Facility is respectfully requesting an IDR for the tag F760 related to transcription of medications. Facility disputes any negative outcome to Resident #9 by the potential deficient practice referenced in the 2567. F760 – Free From Significant Medication Error 1 No adverse effects were noted to Resident 9. 2 The deficient practice has the potential to affect all residents who admit to the facility. 100 % audit of all admitted resident's medications have been completed in past four weeks. Reviewed with provider with no concerns noted.	11/07/2024

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	and acute kidney injury. A hospital Discharge Documentation form, dated 6/24/24, was provided to the facility from the hospital for her readmission to the facility. The form listed Resident 9's hospital discharge medications, including the following medication order: lisinopril (medication to treat high blood pressure) 20 milligrams, one-half tablet (10 mg) every day. There was another section of the form titled "Discharge Plan" which stated "lisinopril 20 milligrams 40 milligrams equals two tablets daily." The Medication Administration Record (MAR), dated June 2024, indicated an order for lisinopril 40 milligrams, 2 tablets (80 mg). Lisinopril 80 milligrams was marked as administered to the resident on 6/25/2024 and 6/26/2024. On 6/26/2024, the order was discontinued and a new order for lisinopril 40 milligrams, administer 10 milligrams once a day was written. This dose was given on 6/27/2024. A Nurse's Note, dated 6/27/2024 at 2:10 P.M., indicated Resident 9 was lethargic, could not keep her eyes open, her blood pressure continued to drop and she had increased shortness of breath. An order was received to send Resident 9 to the emergency room for an evaluation and treatment. A History and Physical Report from the hospital, dated 6/27/2024, indicated the Emergency Medical Services (EMS) reported Resident 9 had altered mental status, bradycardia (slow heartbeat) and hypotension (low blood pressure). Resident 9 was found with a systolic (top number of a blood pressure reading indicating maximum pressure in the arteries) blood pressure of 60, a heart rate of 30, and the EMS administered atropine 0.5 milligrams resulting in an increase of her blood		3 Nursing staff educated on the process and policy for transcribing medications on admission and provider and pharmacy follow up with routine verification of transcribed medications. 4 The DHS or designee will review all admitted resident's medication within 24 hours of admission weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. The DHS or designee will review any findings and corrective action monthly and in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as appropriate. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/07/2024	

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	pressure to 75/36 mmHg (millimeters of mercury) and pulse to 50 bpm (beats per minute). The report indicated the nursing home staff had reported Resident 9's blood pressure had been running low since her readmission to the facility with the systolic blood pressure ranging from 103-121. The staff also reported Resident 9 had blood pressures of 95/61 mmHg and 96/60 mmHg. The staff reported Resident 9's blood pressure had dropped to 98/50 mmHg and her lisinopril medication had been held on 6/25/2024 and 6/26/2024. The report indicated there was significant confusion regarding the Discharge Documentation and the lisinopril dosage. Resident 9 was readmitted to the hospital on 6/27/24 with diagnoses including, but not limited to: - Hypotension secondary to medications with subsequent bradycardia and hypotension with a degree of dehydration. - Acute kidney injury due to hypoperfusion with bradycardia and hypotension and most likely a degree of dehydration. A Minimum Data Set (MDS) assessment, dated 9/24/2024, indicated Resident 9 had moderate cognitive impairment. During an interview, on 10/11/2024 at 10:54 A.M., Pharmacy Technician 26 indicated on 6/25/2024, the pharmacy dispensed lisinopril 40 milligrams 2 tablets for Resident 9's daily medication packaging. During an interview, on 10/15/2024 at 9:14 A.M., RN 5 indicated when Resident 9 returned from the hospital on 6/24/2024, there were many discrepancies with her medications. Resident 9 was on lisinopril 10 milligrams prior to her			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PADDOCK SPRINGS	2695 SHELDON STREET WARSAW, IN 46582

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	hospitalization and should have been on 10 milligrams when she returned to the facility, but another nursing staff member had erroneously transcribed the order for 80 milligrams from the discharge plan. RN 5 indicated the staff should have used the Discharge Documentation orders, not the Discharge Plan for readmission physician orders. Resident 9 was sent back to the hospital for low blood pressures mixed with her other co-morbidities. A professional reference from the National Library of Medicine, https://www.ncbi.nlm.nih.gov/books/NBK482230/, indicated the recommended initial adult dose of lisinopril was 10 mg daily and could be increased to 40 mg daily. Potential side effects included impaired renal (kidney) function and hypotension. A professional reference at Mayoclinic.org indicated the same adult dosing parameters of 10 - 40 mg per day with the added geriatric warning: " ... elderly patients are more likely to have age-related kidney problems, which may require caution and an adjustment in the dose for patients receiving lisinopril." A policy, titled "Guidelines for Medication Orders", was provided by the Director Nursing as current on 10/15/2024 at 1:14 P.M., and was. The policy indicated, " ...Procedures ...2. A current list of orders will be maintained in the electronic clinical record of each resident ...4. Medication orders a. When recording medication orders specify: 1. The type, route, dosage, frequency, strength, of the medication and reason ...." 3.1-48(c)(2)			

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure infection control practices were followed related to lack of changing gloves and handwashing during perineal care and when administering insulin for 1 of 1 resident observed for incontinence care and 1 of 1 resident observed for insulin injection. (Resident 15) Findings include: 1. During an observation, on 10/10/2024 at 7:25 A.M. Certified Nursing Assistant (CNA) 7 was observed to provide incontinence/catheter care to Resident 15. She washed her hands and donned gloves. She used a washcloth and cleaned the catheter. CNA 7 turned the resident over to her right side, and with wet wipes, she washed the residents' buttocks. There was a smear of feces around the resident's rectum. She then placed the dirty wipes on the soiled brief and removed the brief. Lastly, the aide applied a clean brief and pulled up the resident's pants. CNA 7 then removed her gloves and placed them in the trash can and washed her hands. During an interview, CNA 7 indicated she should have removed her gloves and washed her hands after washing the resident's buttocks. 2. During an observation on 10/10/2024 at 8:55 A.M., QMA 8 washed her hands and donned gloves. She cleansed an area on the resident's right lower abdomen with an alcohol pad and with an opened hand, she fanned the area she had just cleansed	F 0880	F880 – Infection Prevention and Control 1 No adverse effects were noted to residents identified. 2 The deficient practice has the potential to affect all residents in the facility. Infection Prevention and Control audit completed throughout the facility. No findings noted. 3 Staff educated on the Infection Prevention and Control policy with a focus on resident care and administering insulin to residents. 4 The ED/DHS or designee will review 5 employees weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. The ED/DHS or designee will review any findings and corrective action monthly and in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as appropriate. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/07/2024	11/07/2024

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	During an interview, on 10/10/2024 at 8:56 A.M., QMA 8 indicated she should not have fanned the area. On 10/25/2024 at 4:05 P.M., the Director of Nursing provided the policy titled," Perineal Care for Incontinence", dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...7. Pay particular attention to infection prevention and control techniques when performing pericare, to prevent the introduction of contamination that may lead to a urinary tract infection...." A policy for glove use was requested but none was not provided prior to the survey exit. On 10/15/2024 at 4:05 P.M., the Director of Nursing provided a policy titled, "Injectable Medication Administration", with a revision date of 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated: "...Expose the area to be injected and clean with an alcohol wipe...." 3.1-18(b)(1)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 8, 9, 10, 11, 15 and 16, 2024 Facility number: 000491 Residential Census: 33	R 0000		

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were approved by a licensed nurse for 5 of 7 residents reviewed for medications. (Residents 6, 7, 8, 3 & 4) Findings include: 1. The record for Resident 6 was completed on 10/16/2024 at 10:28 A.M. Diagnoses included, but were not limited to: hypertension, anxiety, depression and congestive heart failure. Resident 6's medication orders included: Imodium (anti-diarrheal) 125 mg (milligram) 2 tablets after the first loose stool, then 1 tablet after each loose stool up to 4 tablets in 24 hours PRN (as needed) for diarrhea and Acetaminophen (analgesic) 500 mg 2 tablets two times daily PRN for severe pain. The Medication Administration Record (MAR), dated July 2024, indicated Resident 6 had received Imodium on 9/9/2024 from Qualified Medication Aide (QMA) 22 and on 9/14/2024 from QMA 23. The clinical record lacked the documentation to show the QMA's had obtained authorization from a licensed nurse prior to the administration of the medication. The MAR, dated September 2024, indicated the resident had received Acetaminophen on 9/7/2024 from QMA 21.	R 0246	R246 – Health Services-Deficiency 1 No adverse effects were noted to residents identified. 2 The deficient practice has the potential to affect all residents in the facility. 100% audit of all resident charts completed. Provider notified of any findings with no concerns noted. 3 Nursing staff will be educated on the policy related to Qualified Medication Assistants administering PRN medications with a focus on documenting authorization from a licensed nurse for administration and follow up. 4 The DHS or designee will review 5 resident charts for PRN medication administration weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. The DHS or designee will review any findings and corrective action monthly and in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as appropriate. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	11/07/2024

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	The clinical record lacked documentation to show the QMA had obtained authorization from a licensed nurse prior to the administration of the acetaminophen medication. 2. The record for Resident 7 was completed on 10/15/2024 at 3:33 P.M. Diagnoses included, but were not limited to: obesity, hypertension and stage 3 kidney disease. Resident 7's medication orders included: Imodium A-D 2 mg (milligram) tablet 1 tablet three times a day PRN (as needed) and Tylenol 325 mg 2 tablets every 6 hours PRN. The Medication Administration Record (MAR) dated July 2024 indicated Resident 7 had received Imodium on the following dates: 7/13/2024 from QMA 13. 7/14/2024 from QMA 23. 7/15/2024 from QMA 12. 7/21/2024 from QMA 19. 7/22/2024 from QMA 16. 7/23/2024 from QMA 18. 7/27/2024 from QMA 13. The clinical record lacked the documentation to show the QMA's had obtained authorization from a licensed nurse prior to the administration of the medication. The MAR dated August 2024 indicated the resident had received Imodium on the following dates: 8/1/2024 from QMA 20. 8/10/2024 from QMA 15. 8/17/2024 from QMA 19 and QMA 16. 7/18/2024 from QMA 12.		Compliance Date: 11/07/2024	

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	The clinical record lacked the documentation to show the QMA's had obtained authorization from a licensed nurse prior to the administration of the medication. The MAR dated October 2024 indicated the resident had received Imodium on the following date: 10/2/2024 from QMA 12. The clinical record lacked the documentation to show the QMA's had obtained authorization from a licensed nurse prior to the administration of the medication. 3. The record for Resident 8 was completed on 10/16/2024 at 9:10 A.M. Diagnoses included, but were not limited to: subdural hematoma, retention of urine, insomnia and chronic pain. Resident 8's medication orders included: morphine 0.5 ml (milliliters) every 2 hours as needed for severe pain. The MAR dated October 2024 indicated Resident 8 had received the morphine on the following dates: 10/4/2024 from QMA 24. 10/6/2024 from QMA 13. 10/7/2024 from QMA 16. 10/8/2024 from QMA 24. 10/10/2024 from QMA 16. 10/13/2024 from QMA 13. The clinical record lacked the documentation to show the QMA's had obtained authorization from a licensed nurse prior to the administration of the medication.			

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	During an interview, on 10/16/2024 at 1:03 P.M., the Assisted Living Director indicated QMAs needed to notify the nurse in charge and obtain approval to give a PRN medication and a nurse needed to complete a follow up assessment. She indicated if she was on the unit, she would sign off the PRN being given, but indicated it was just a verbal consent to administer. 4. A record review for Resident 3 was completed on 10/15/2024 at 1:20 P.M. Diagnoses included Parkinson's disease, schizophrenia and anxiety disorder. A Physician's Order, dated 8/4/2023, indicated acetaminophen 325 milligram administer 2 tablets as needed every four hours for pain. The Medication Administration Record (MAR), dated June 2024, indicated Resident 3 had acetaminophen 325 milligrams 2 tabs administered on 9/5/2024 at 12:10 A.M. by QMA 14 and at 11:27 P.M. by QMA 17. The medical record did not have any documentation of a nurse providing approval prior to administration of the acetaminophen. 5. A record review for Resident 4 was completed on 10/15/2024 at 2:25 P.M. Diagnoses included, but were not limited to: failure to thrive, dementia, anxiety disorder and depression. A Physician's Order, dated 8/28/2024, indicated to give lorazepam (antianxiety medication) concentrate 2 milligrams per milliliter give 0.5 milligrams every 2 hours as needed for anxiety and agitation. The Medication Administration Record, dated September 2024, indicated lorazepam concentrate			

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	was administered by QMA's without documentation of approval to administer on the following dates: - 9/5/2024 at 5:22 A.M. by QMA 14 - 9/10/2024 at 1:03 A.M. by QMA 17 - 9/10/2024 at 5:01 A.M. by QMA 17 - 9/10/2024 at 8:58 P.M. by QMA 20 - 9/11/2024 at 6:45 P.M. by QMA 20 A Physician's Order, dated 6/10/2024, indicated to give lorazepam 0.5 milligrams every 4 hours as needed for agitation. The Medication Administration Record, dated September 2024, indicated lorazepam was administered by QMA's without documentation of approval to administer on the following dates: - 9/2/2024 at 6:59 P.M. by QMA 17 - 9/3/2024 at 9:46 P.M. by QMA 20 - 9/4/2024 at 6:13 P.M. by QMA 24 - 9/5/2024 at 7:59 P.M. by QMA 16 - 9/7/2024 at 9:28 A.M. by QMA 13 - 9/8/2024 at 1:11 A.M. by QMA 20 A Physician's Order, dated 8/28/2024, indicated to give morphine (pain medication) concentrate 100 milligrams per 5 milliliters and to give 5 milligrams every 2 hours as needed for pain The Medication Administration Record, dated September 2024, indicated morphine concentrate was administered by QMA's without documentation of approval to administer on the following dates: - 9/4/2024 at 3:10 A.M. by QMA 2 - 9/4/2024 at 8:40 P.M. by QMA 24 - 9/5/2024 at 5:22 A.M. by QMA 14 - 9/6/2024 at 5:45 A.M. by QMA 17 - 9/7/2024 at 3:24 A.M. by QMA 16 - 9/7/2024 at 5:30 P.M. by QMA 16			

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	- 9/8/2024 at 1:11 A.M. by QMA 21 - 9/10/2024 at 1:03 A.M. by QMA 17 - 9/10/2024 at 3:03 A.M. by QMA 17 - 9/10/2024 at 5:01 A.M. by QMA 17 During an interview, on 10/16/2024 at 1:03 P.M., the Director of Assisted Living indicated the QMA needed to notify the nurse in charge and obtain approval prior to administering an PRN (as needed) medication. She indicated the nurse giving the authorization to administer the medication should sign the post-assessment of effectiveness. She indicated the QMA's usually received verbal consent to administer PRN (as needed) medications. A policy was provided, on 10/16/2024 at 2:46 P.M., by the Director of Nursing titled, "Administration of PRN Medications". The policy indicated " ...If PRN medication is to be administered by a QMA the Standard of Practice for PRN medication administration by a Qualified Medication Assistant shall be observed under the direction of licensed nurse ...."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 5 of 7 residents. (Residents 6, 7, 8, 2 & 3) Findings include: 1. The record for Resident 6 was completed on 10/16/2024 at 10:28 A.M. Diagnoses included, but were not limited to: hypertension, anxiety, depression and congestive heart failure.	R 0356	R356 – Clinical Records-Noncompliance 1 No adverse effects were noted to residents identified. 2 The deficient practice has the potential to affect all residents in the facility. 100% audit of all resident charts completed. All charts and documentation updated with additional information. 3 Admission staff and nursing	11/07/2024

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	The emergency information file did not have a hospital preference listed on the provided face sheet for Resident 6.. 2. The record for Resident 7 was completed on 10/15/2024 at 3:33 P.M. Diagnoses included, but were not limited to: obesity, hypertension and stage 3 kidney disease. The emergency information file did not have a hospital preference listed on the provided face sheet for Resident 7. 3. The record for Resident 8 was completed on 10/16/2024 at 9:10 A.M. Diagnoses included, but were not limited to: subdural hematoma, retention of urine, insomnia and chronic pain. The emergency information file did not have a hospital preference listed on the provided face sheet for Resident 8.4. A record review for Resident 2 was completed on 10/15/2024 at 11:42 A.M. Diagnoses included, but were not limited to: psychotic disorder with delusions and diabetes mellitus type 2. On 10/17/2024 at 11:17 A.M the Resident Emergency Information File was reviewed. The information for Resident 2 did not have a hospital preference listed. 5. A record review for Resident 3 was completed on 10/15/2024 at 1:20 P.M. Diagnoses included, but were not limited to: Parkinson's disease, schizophrenia and anxiety disorder. On 10/17/2024 at 11:17 A.M. the Resident Emergency Information File was reviewed. The information for Resident 3 did not have a hospital		staff will be educated on the policy related to required information for Emergency files. 4 The DHS or designee will review 5 resident charts for all appropriate information on emergency files weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. The DHS or designee will review any findings and corrective action monthly and in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as appropriate. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. Compliance Date: 11/07/2024	

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	preference listed. During an interview with the Director of Assisted Living, on 10/16/2024 at 1:00 P.M., she indicated the emergency file should include the face sheet, resident contacts and code status. She indicated for hospital preference, if the family did not want the resident sent to the facility's default hospital, then the resident's preferred hospital should be listed on the face sheet. A policy was provided by the Director of Nursing, on 10/16/2024 at 2:46 P.M., titled, "Emergency Information File Guidelines". The policy indicated, " ...2. The file shall contain the following information: a. The resident's name, sex, room or apartment number, phone number, age, or date of birth b. The resident's hospital preference c. The name and phone number of any legally authorized representative. d. The name and phone number of the resident's physician of record. e. The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. f. Listing of any known allergies. g. A copy of advanced directives. h. A copy of power of attorney or guardianship. i. A photograph of the resident, armband or other identifying measures ...."			